COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Enhanced Primary Care (version date (9/5/14)

Beginning July 1, 2014 the Department - in partnership with the Regional Care Collaborative Organizations (RCCOs) - will initiate the first steps to recognize and reimburse Primary Care Medical Providers (PCMPs) who offer services beyond the traditional fee-for-service primary care model of care. This preliminary list of Enhanced Primary Care services reflects the RCCO's and the Department's thoughts about services and supports that are applicable to all patient populations (including children, adults, older adults, and individuals with disabilities), and are likely to help achieve the overall goals of the Accountable Care Collaborative. The nine factors have been adapted from Colorado Senate Bill 07-130 concerning medical homes for children, national patient-centered medical home models [e.g. National Committee for Quality Assurance (NCQA) 2014], evidence-based practices, RCCO recommendations, and other key Department initiatives designed to incentivize quality improvement. PCMPs who meet five of the nine following factors may be eligible for an additional per member per month (PMPM) payment. Details regarding financing, payment amounts, and other operational issues are still being finalized between the Department and RCCOs.

Enhanced Primary Care Factors:

1. The PCMP has regularly scheduled appointments (at least one time a month) on a weekend and/or on a weekday outside of typical workday hours.
2. The PCMP provides timely clinical advice by telephone or secure electronic message both during and after office hours. Patients and families are clearly informed about these procedures.
3. The PCMP uses available data (e.g., SDAC, clinical information) to identify special patient populations who may require extra services and support for medical and/or social reasons. The Practice has procedures to proactively address the identified health needs.
4. The PCMP provides on-site access to behavioral health care providers.
5. The PCMP collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents and/or developmental screening for children (newborn to five years of age) using a Medicaid approved tool. In addition, the practice has documented procedures to address positive screens and has established relationships with providers to accept referred patients or utilizes the standard referral and release form created by the Behavioral Health Organizations.
6. The PCMP generates lists of patients actively receiving care coordination.
7. The PCMP tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information.
8. The PCMP will accept new Medicaid clients for the majority of the year.
9. The PCMP and patient/family/caregiver collaborate to develop and update an individual care plan

Attached are detailed descriptions of how the nine factors will be measured by the RCCOs.

Following are detailed descriptions of the nine factors, including the goal of the factor, how it should be measured, and potential procedures that practices can implement to achieve the factor. Documentation will be required to verify that a practice meets the definition for at least five of the factors in order to qualify for an additional per member per month (PMPM) payment. All documented processes and operating procedures must include a date of implementation or revision.

1. **The PCMP has regularly scheduled appointments (at least one time a month) on a weekend and/or on a weekday outside of typical workday hours.**

Goal: Enable working individuals and/or parents to schedule routine and non-urgent appointments in the evenings or on weekends to improve client experience and treatment follow-up, and to reduce utilization of the emergency departments for non-urgent care.

Measurement: RCCOs will review published patient materials, a month-long schedule with data showing the availability and use of appointments outside the normal hours of operation. Normal business hours are defined as 7:30 am through 5:30 pm, Monday through Friday (excluding holidays).

Possible Procedures (from NCQA 2014):
The practice schedules appointments outside of normal business hours (Monday through Friday, 7:30 am-5:30 pm). For example a practice may open appointments at 7 am or remain open until 8 pm on certain days or it may be open two Saturdays each month. Providing extended access does not include:
- Opening daytime appointments when a practice would otherwise be closed for lunch (on some or most days).
- Opening daytime appointments when a practice would otherwise close early (e.g., a weekday afternoon or holiday).

Practices are encouraged, but not required, to first assess the needs of their patients for appointments outside normal business hours and then to evaluate if these appointment times meet the needs of the patients.

References:
- NCQA 2014 1:A2 "Providing routine and urgent-care appointments outside regular business hours."
- The Medical Home Index: Pediatric #1.2 Level 3 "individual needs prompt weekend or other special appointments."

Alignment with State and Department Initiatives: Emergency department utilization

2. **The PCMP provides timely clinical advice by telephone or secure electronic message both during and after office hours. Patients and families are clearly informed about these procedures.**

Goal: Adults, parents/caregivers, and adolescents receive timely, personalized answers to their medical questions from their primary care practice when the office is both open and closed.

Measurement: RCCOs will review published patient handouts and/or documented procedure(s) describing how the PCMP provides clinical advice to patients by telephone or using a secure interactive electronic system (e.g., electronic message, Web site, patient portal), whether the office is open or

closed. Questions are answered by a person, not a recorded message. The practice defines the time frame for responses based on day, time of day, and form of communication (phone or electronic message).

Possible Procedures (from NCQA 2014): Clinicians return calls and respond to secure electronic messages in the time frame defined by the practice to meet the clinical needs of the patient population. The practice may have different standards for when the office is open and when the office is closed and may have different standards for electronic versus telephonic communications. If patients can submit requests for clinical advice after office hours, the practice has an obligation to provide a timely response. The practice defines the types of inquiries that should be made electronically, and its response time frame (e.g., a secure message sent after hours receives an automatic reply informing the sender that urgent situations require a phone call and that "routine" electronic messages will be responded to the next business day).

References:
- Colorado Senate Bill 07-130 "Twenty-four hour telephone care."
- NCQA 2014 1:B2-3 "Providing timely clinical advice by telephone" and "Providing timely clinical advice using a secure, interactive electronic system."
- The Medical Home Index: Pediatric #1.2 Level 2 "Standardized office communication methods are identified to the family by the practice (e.g. call-in hours, phone triage for questions, or provider call back hours)."

Alignment with Department Initiatives: Emergency department utilization

3. **The PCMP uses available data (e.g., SDAC, clinical information) to identify special patient populations who may require extra services and support for medical and/or social reasons. The Practice has procedures to proactively address the identified health needs.**

Goal: Practices will use evidence-based decision support tools to manage the health of its patients in an effort to improve patient outcomes and make progress on key performance indicators.

Measurement: RCCOs will review electronic or paper lists of identified special patient populations and samples of efforts to proactively contact patients for services (e.g., call logs, letters sent to patients, scripts of phone reminders, and/or screen shots of electronic notices). Practices are expected to have documentation of their criteria and process for identifying patients, as well as procedures for proactively contacting patients.

Possible Procedures: Special patient populations may be identified through an electronic health record, SDAC, key staff members, or billing or practice management system. While the emphasis of care should be on the whole person over time, methodologies for identifying patients could include diagnosis, a global risk score, or a set of risk indicators (e.g., number of medications, ER/hospitalization use, or a systematic assessment of psychosocial complexity). Once identified, PCMPs must use their list(s) to deliver proactive reminders to address the targeted health care needs. For example, registries could identify patients who need preventive care, immunizations, or chronic care services. The practice may use mail, telephone, or e-mail, directly or through external providers (e.g., vendors, HIE) to remind patients when services are due.

References:
- Colorado Senate Bill 07-130 "Health maintenance and preventative care."

- Comprehensive Primary Care Initiative (CPCI) 2013 Milestones,
- The Medical Home Index: Adult domain 2.1
- NCQA 2014 Factors 3D and 4A.
- The Medical Home Index: Pediatric #2.1 Level 2 "Lists of children with special health care needs are extracted electronically by diagnostic code" and Level 3 "A CSHCN list is generated by applying a definition, the list is used to enhance care +/or define practice activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups)."

Alignment with Department Initiatives: ACC, Health Home, Medicare-Medicaid Demonstration

4. **The PCMP provides on-site access to behavioral health care providers.**

Goal: Identify and treat mental health and substance use problems early in a patient's life by increasing access to behavioral health services and reducing the stigma regarding behavioral health treatment.

Measurement: RCCOs will review materials that explain how behavioral health services are provided at the primary care practice site, such as contracts with or employment of licensed behavioral health providers. Behavioral health services must be delivered face-to-face (including live video) between a client and a licensed behavioral health provider at the primary care site. Behavioral health services must be available for the equivalent of at least 1 day a month.

Possible Procedures: The practice provides on-site access to face-to-face (including live video) behavioral health services with a licensed professional. Sharing of billing and charting systems is not required.

Source:
- Colorado Senate Bill 07-130 minimum assurances for Medical Homes for Children "Coordination of medications, specialists and therapies."
- NCQA 2014 Factor 5:B4 "Integrates behavioral healthcare providers within the practice site"

Alignment with Department Initiatives: State Health Innovation Plan (SIM)

5. **The PCMP collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents and/or developmental screening for children (newborn to five years of age) using a Medicaid approved tool. In addition, the practice has documented procedures to address positive screens and has established relationships with providers to accept referred patients or utilizes the standard referral and release form created by the Behavioral Health Organizations.**

Goal: Identify developmental, mental health, and substance use problems early and facilitate access to appropriate treatment.

Measurement: RCCOs will review a report, a form, or the practice's written or electronic procedure for conducting, collecting, and documenting behavioral health and developmental screenings. In addition, the practice provides at least one example of a formal or informal agreement with a behavioral health care provider. Examples of agreements could include a referral request form (e.g., "Referral and Release Form Behavioral Health Services" developed by the Behavioral Health Organizations), a Colorado

Medical Society primary care-specialty care compact, other documentation describing the details regarding the exchange of information, or internal processes for practices with partial or full integration of behavioral health care services.

Possible Procedures (from NCQA 2014 3:C9 and 5:B3):
For newborns through 5 years of age, the Practice implements periodic developmental screening using a Medicaid-approved standardized screening test. For adolescents and adults, the Practice utilizes Medicaid-approved screening tools (e.g., SBIRT, PHQ-9) to assess whether the patient or the patient's family has mental health/behavioral conditions or substance use disorder (e.g. stress, alcohol, prescription drug abuse, illegal drug use, maternal depression).

Agreements between primary care providers and behavioral health care providers may be formal or informal and may describe the expectations or embed them in a tool such as a referral request form. The agreement is an articulation of the arrangements for the exchange of information. Agreements typically indicate the type of information that will be provided when referring a patient to the behavioral health provider and expectations regarding timeliness and content of response from the specialist.

References:
- Colorado Senate Bill 07-130 minimum assurances for Medical Homes for Children "Coordination of medications, specialists and therapies."
- NCQA 2014 Factor 3:C7 "Mental health/substance use history of patient and family."
- NCQA 2014 Factor 3:C9 "Depression screening for adults and adolescents using a standardized tool."
- NCQA 2014 Factor 3:C8 "Developmental screening using a standardized tool."
- NCQA 2014 Factor 5:B3 "The practice maintains agreements with behavioral healthcare providers."

Alignment with Department Initiatives: State Health Innovation Plan (SIM)

6. **The PCMP generates lists of patients actively receiving care coordination.**

Goal: Improve the health and outcomes of patients and families through increased coordination of care.

Measurement: RCCOs will review a list (electronic or paper) identifying patients and families actively receiving care coordination from the PCMP that includes the last service provided or last attempt to provide coordination. For practices where RCCOs are providing care coordination, the PCMP must be able to create a list of clients actively receiving care coordination and demonstrate collaboration with the RCCO for managing the care of the client.

Possible Procedures: The PCMP tracks patients receiving care coordination, including the date care coordination services began, the date care coordination services were terminated and the reason why, and either the last care coordination service provided or the last attempt to coordinate care for the patient or family. For PCMPs who utilize RCCOs to deliver care coordination, the PCMP identifies clients receiving care coordination services and documents conversations with care coordinators and individualized care management activities.

References:

- Colorado Senate Bill 07-130 minimum assurances for Medical Homes for Children "Coordination of medications, specialists and therapies."
- Implied from medical home concepts

Alignment with Department Initiatives: ACC, Health Home, Medicare-Medicaid Demonstration

7. **The PCMP tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information.**

Goal: Improve access to specialty care by making "smart" referrals and following up with specialists to collect treatment recommendations and other relevant information.

Measurement: RCCOs will review a documented specialty care referral process for practice staff or a Colorado Medical Society primary care-specialty care compact, *and* at least one example or report demonstrating that the process has been implemented.

Possible Procedures (from NCQA 2014): Referrals to medical specialists, mental health and substance abuse specialists and other services tracked by the practice using a log or electronic system are determined by the clinician to be important to a patient's treatment, or as indicated by practice guidelines (e.g., referral to a surgeon for examination of a potentially malignant tumor; referral to a mental health specialists for a patient with depression).

To ensure "smart" referrals, the referring clinician provides a succinct reason for the referral, which may be stated as "the clinical question" (i.e. the general purpose of the referral) to be answered by the specialist. The practice includes follow-up communication or information in the referral. The referring clinician indicates the urgency of the referral in concrete terms and includes details about the reasons for an urgent visit.

In addition, the referrals include relevant clinical information; for example:
- Current medications
- Diagnoses, including mental health, allergies, medical and family history, substance use and behaviors affecting health
- The reason for the referral and evaluation details
- Clinical findings and current treatment
- Follow-up communication or information

Patient demographic information includes:
- Communication needs
- Primary language
- Relevant cultural or ethnic information

Including the referring primary care clinician's care and treatment plan in the referral, in addition to test results/procedures, can reduce duplication of services, tests or treatments.

References:
- Colorado Senate Bill 07-130 minimum assurances for Medical Homes for Children "Coordination of medications, specialists and therapies."

- NCQA 2014 5: B Referral Tracking and Follow-up, particularly 5:B4 "Gives the consultant or specialist the clinical question, the required timing and the type of referral" and 5:B5 "Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan."
- The Medical Home Index: Pediatric #2.4 Level 2 "Specialty referrals use phone, written and/or electronic communications; the PCP waits for or relies upon the specialists to communicate back their recommendations."

Alignment with Department Initiatives: Medical Neighborhood

8. **The PCMP will accept new Medicaid clients for the majority of the year.**

Goal: Ensure all Medicaid clients have access to a medical home for primary care services.

Measurement: RCCOs will work with PCMPs to identify how many new Medicaid clients the practice is able to accept, either as a distinct number or percentage of the PCMP's patient panel. The RCCOs will monitor a PCMP's "open" status on the Monthly Provider Directory to see that they are "open" for at least 7 out of 12 months.

Possible Procedures: Practices can individually define how many new Medicaid clients they will accept, either as a percentage of the practice's patient panel or a defined number. RCCOs will work with PCMPs to place unattributed clients.

Source: RCCO proposed concept

Alignment with Department Initiatives: Provider Engagement, ACC, Health Home, ACA Expansion

9. **The PCMP and patient/family/caregiver collaborate to develop and update an individual care plan.**

Goal: Deliver whole-person care that engages the patient/family in the decision-making process.

Measurement: RCCOs will review two individualized care plans for patients/children receiving care coordination. Practices can utilize their own format for the individualized care plan, either paper-based or electronic; however, the care plan must include documentation of at least 3 of the following features:
- Incorporates patient preferences and functional/lifestyle goals
- Identifies treatment goals
- Assesses and addresses potential barriers to meeting goals
- Includes a self-management plan
- Is provided in writing to the patient/family/caregiver

Possible Procedures (from NCQA 2014 4B): The care team and patient/family/caregiver collaborate on developing and updating an individualized care plan that addresses whole-person care. The care plan specifies the services offered by and responsibilities of the primary care practice and, if appropriate, integrates with a care plan created for the patient by a non-primary care specialty practice, to avoid potential overlap or gap in services and care.

CMS defines a care plan as, "The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome)."

References:
- Colorado Senate Bill 07-130 minimum assurances for Medical Homes for Children "Anticipatory guidance and health education" and declaration 25.5-1-1(b) that states "infants, children, and adolescents and their families work best with a health care practitioner who knows the family and who develops a partnership of mutual responsibility and trust."
- NCQA 2014 4B
- The Medical Home Index: Pediatric #2.2 Level 3 "The team (including PCP, family, and staff) develops a plan of care for CSHCN which details visit schedules and communication strategies; home, school and community concerns are addressed in this plan. Practice back up/cross coverage providers are informed by these plans."
- The Medical Home Index: Pediatric #3.1 Level 3 "Care coordination activities are based upon ongoing assessments of child and family needs; the practice partners with the family (and older child) to accomplish care coordination goals."
- The Medical Home Index: Pediatric #3.2 Level 2 "Families (and their older CSHCN) are regularly asked what care supports they need; treatment decisions are made jointly with the PCP" and Level 3 "Families (and their older CSHCN) are given the option of centralizing care coordination activities at and in partnership with the practice."

Alignment with Department Initiatives: Emergency department utilization, ACC, Health Home, Medicare-Medicaid Demonstration, State Health Innovation Plan (SIM)